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LEADING ARTICLES

TREATMENT OF SOME FORMS OF CEREBRAL DISORDERS, WITH A REPORT OF THREE CASES.

G. B. HASSIN, M. D.

CHICAGO, ILL.

THERE is among general practitioners a common belief that the treatment of nervous disorders is a thankless task. The diagnosis, they say, may be made with the greatest accuracy, but the patient gains very little by this, if he be suffering from a tabes, or syringomyelia, or different forms of atrophies, etc. Correct as such an opinion may be, there, however, is a large class of nervous diseases which, if properly diagnosed and timely given a proper treatment, crowns the physician's efforts with brilliant results. Here belong different so-called functional disorders, as hysteria, neurasthenia, and almost all syphilitic affections of the central nervous system, excepting the so-called "parasyphilitic" diseases, as tabes dorsalis, dementia paralytica, the syphilitic nature of which is not universally accepted. The main trouble is that it is not always easy to establish with certainty the etiological factor in a given case, be it hysteria or syphilis, and thus the practitioner neglects or misses the opportunity of applying at suitable time the life. This is particularly true for syphilitic

radical treatment, losing precious time with lamentable results to the patient's health and affections of the central nervous system, as it is often impossible to prove the existence of any specific infection in the history of the patient or his family, while the specific treatment even in such cases if timely administered often works wonders. This is the reason why Prof. A. Strümpell recommends the antisiphilitic treatment in doubtful cases of apoplectic attacks, as there is nothing to lose and much perhaps to gain,* and another authority Prof. Grasset, in France, insists upon giving specific remedies in all cases of organic lesions of the central nervous system in which there is the slightest probability or possibility of specific infection.†

I can but agree with the opinions of these two competent neurologists and to the case reported by me elsewhere‡ I can now add two more in which the treatment proved most successful despite the utter impossibility of finding specific taint in the histories of the patients. The first reported case referred to a physician, 65 years of age, who from time to time felt numbness in the fingers, slight transient paralysis of the limbs, and, finally, permanent palsies developed, first in the lower limb, and afterwards in the right upper extremity, thus spreading upwards from the feet to the shoulder. The doctor thought he suffered from rheumatism for the last thirty-five years, never suspected syphilis; was denying same most persistently, and I could give him the necessary treatment only when he became completely helpless and indifferent. The paralysis clinically developed under the form of progressive ascending hemiplegia, and anatomically was undoubtedly due to an endarteritis of art. fossae sylviae. The nature of the endarteritis was a specific infection, because inunctions of one dram daily of blue ointment coupled with taking internally potassium iodide (6.0 daily) brought on a rapid improvement, and the patient gradually recovered. He enjoyed perfect health for five years more, when he died from a pulmonary hemorrhage.

The second case was observed by me here in Chicago. Mr. G., 58 years of age, went

* A. Stumpell: A Text-Book of Medicine, Third Amer. Edition, 1901, p. 1128.

† Le traitement spécifique dans les maladies organiques des centres nerveux sans syphilis antérieure, par Prof. Grasset (Revue Neurol. 1902, No. 23, December 15.)

‡ G. B. Hassin: Acute Progressive Hemiplegia (The Clinical Review, Chicago, 1904, September, pp. 404-412.)

to bed on January 6th, 1906, in apparently healthy condition, but did not rise the next morning at the usual time, and could be aroused from his deep sleep with the greatest difficulty. When aroused, he kept awake for a while and fell asleep again, and was sleeping in the presence of excited relatives and friends. When I saw him in the evening of the same day I found him sitting on a chair with an astonished look in his face, surrounded by a crowd of frightened friends and crying relatives, and when not disturbed falling asleep again. His sleep did not differ from a common sleep, and when aroused would yawn and immediately try again to sleep. To my question, why is not the patient in bed, his wife answered that the doctor they summoned in the hurry on account of my retarded visit suspected opium poisoning, and therefore recommended keeping the patient awake, making him walk or sitting up and doing all other things usually resorted to in opium poisoning cases. The first examination of the patient revealed highly contracted pupils which did not respond to light or accommodation, exaggerated tendon and skin reflexes, a full tense pulse of 48, marked arterio-sclerosis, normal temperature, normal heart, lungs and kidneys. There were no paralytic phenomena, the patient could stand on his feet, move around, understood and answered questions, did not complain of headache or anything else; in fact, did not care for anything, falling asleep during the examination. The eyes were kept half open, which I explained by his desire to sleep, but the movements in all directions were normal. The only thing I could diagnose was an increased intracranial pressure of unknown cause to me, for which proposition spoke the rare pulse, contracted pupils and the high tension of the pulse. Accordingly, I ordered ice to the head, dry cupping glasses to the neck and dorsum, mustard plasters to the calves, enemata for the bowels and drops of tincture valerianae ethereave as a slight stimulant. The next day the patient was aroused from his sleep somewhat easier, inquired for his dress, intending to go to his office, but immediately fell asleep again. At this time, i.e., the second day of the disease, I showed the patient to Prof. D. Brower, of Rush Medical College. He found the patient in the condition described above, and thought of a meningitis with an exudative fluid in the brain. He recommended digitalis and some diuretics and a lumbar puncture to decrease the intracranial pressure. I accordingly prescribed an infusion digitalis 0.36 par 150.0, ac. muriat. dil. 1.0, syr. simpl. 30.0. Sig.: A tablespoonful every two hours. With the lumbar punc-

ture I decided to wait. The condition of the patient grew worse, something like dyspnea developed, and when I was hurriedly summoned to the patient on the third day of the disease I noticed drooping of the left lid, i.e., a left-sided ptosis. He could slightly lift the lid, and with the greatest difficulty. This new sign showed that there were some vascular disorders in the brain which brought on a partial paralysis of the oculomotor nerve of the central type, and I at once suspended the digitalis and the acetate of potassium, and administered the autospilitic treatment in the form of ung. hydrarg. cinerei (50%) 4.0, to be used daily in different portions of the body, and potassium iodide was given in doses of 6.0 daily. It was impossible to find in the history of this patient any specific infection, or anything else, because the patient was, as he claimed, always well, never had any trouble with his health; had been leading a very active, busy life, never indulged in any drinking, was a devoted husband and father, has three healthy children, and his wife never had any miscarriages or abortions.

The effects of the treatment showed in about six days, the pupils became gradually larger and unequal; there appeared some reaction to light and accommodation but the tendon reflexes disappeared almost entirely. While he was sleeping the whole day, he was sitting up in the evening, talking to his friends and behaving as a perfectly healthy person. The improvement was slowly progressing and when three weeks after treatment he was shown to Prof. Brower again the improvement regarding the condition of the pupils and general behavior of the patient was so marked that Dr. Brower pronounced the success of the treatment as marvelous. Unfortunately the patient could not bear the KJ, which caused severe neuralgia of the right side of the head, a rhinitis and conjunctivitis, besides different stomach disorders, and I had to resort to different substitutions of potassium iodide, as nucleo-iodides, iodipin (10%), saiodin, which, however, could not be equally borne. I had to rely on mercury only, which was given in the form of frictions (ung. hydr. cinerei fortis) during thirty days followed by some tonic during four to five weeks (ac. arsenicosi 0.06, ferr hydr. red., 2.0, chin. sulph. 2.0, extr. gent. q.s. ut. f. pil. No. 30. S.: One pill twice a day after meals.) The specific treatment was given every two months, twice in the form of inunctions and once in the form of pills (hydr., protoiod 2.0, extr. opii 0.3, extr. gent. q.s. ut. f. pl. N. 30. S.: One pill to be taken in the morning), because when left without mercury, the patient used to fall in a state of apathy; to feel an increased desire to sleep and show no in-

terest for domestic affairs. After the second course of thirty inunctions the patient improved to such a degree that he could make a trip to Texas and come back alone. The pupils were unequal, on the left side larger than on the right, but normally reacted to light and accommodation. The tendon reflexes reappeared and were normal. The sleeping condition passed away entirely, and the patient started to show some interest in his family and business affairs, was behaving normally not only in the evenings, but also in the day-time, and the only traces of his disease were the drooping of the left lid, which he could at will easily raise, and lack of ambition and energy. He was complaining of tiresomeness, weakness, which I tried to combat with all kinds of tonics and open air treatment, so that in August the patient was strong enough and well prepared for a third course of mercurial treatment with inunctions which I recommended he should have taken in Hot Springs, Ark. When back, there was no drooping of the left lid, the pupils were in the same condition, but a great anemia developed, for which I ordered fresh air, good nourishment, no more specific treatment and as a tonic: *Tincturae chinae comp.* 30.0, *sol. ars.* Fowler's 4.0, *tincturae nucis vomicae* 8.0. S.: Twenty-five drops twice a day before meals.

Since September up to this time the patient had no mercury, but tried to take some iodid preparations, but unsuccessfully, and while there are none of the symptoms or signs of his sickness, with the exception of inequality of the pupils, and while the patient shows the same amount of intellect as before the sickness, he does not feel the same energy as before, preferring to stay within doors or leisurely lying in bed, complaining of weakness.

The scope of the paper does not allow me to minutely discuss the pathology of the case, but the success of the specific treatment in this case undoubtedly proves that we have here to deal with a syphilitic endarteritis of one of the branches of the middle cerebral artery coupled with a basal gummatous meningitis. The endarteritis produced thrombosis of the corresponding branch of the cerebral artery, which resulted in nutritive disorders of some portion of the brain, while the gummatous meningitis which we must suspect here would be responsible for the also partial paralysis of the oculomotor nerve. The exact localization of the affection of the later is sometimes impossible to determine, though Erb* tries to give some differential points for the diagnosis, but he after all ad-

mits that sometimes it is impossible to give the exact localization of the lesion of this nerve. Thus, the diagnosis in this case will be a partial oculomotor paralysis (paralysis of the upper branch of the oculomotor nerve) due to an endarteritis of some branches of the middle cerebral artery. Regarding the sleeping condition I would not try to offer any explanation, as even the nature of comatous condition in hemorrhages of the brain, or of a normal sleep is not sufficiently explained scientifically, and we only must admit that the abnormal sleeping state of Mr. G. was due to nutritive disorders of the cerebral tissue, because of a disease of the vessels.

In the second case I had to deal with a right-sided hemiplegia which suddenly occurred in a girl 16 years of age. Miss B. went on May 28, 1906, visiting her friends, and while sitting and talking to them suddenly felt darkness before the eyes, was unable to move; tried to scream, but could not, pushed herself from the chair to get up, but fell down to the ground. Physicians were called to her, when she was brought home, and on the third day after the attack I was invited to see the patient. She was complaining in a peevish monotonous manner, that she is "so helpless," being absolutely unable to make the slightest movement with the right upper extremity, while the lower limb could be slightly moved from place to place, but flexion or extension of the leg were impossible. Besides the paralysis of the right limbs there was a paresis of the right lower half of the face, but on the part of other cranial nerves there were no abnormalities.

The pupils were normal and reacted on light and accommodation. The reflexes on the paralyzed side were exaggerated, the Babinski's sign present.

The sensibility was on the paralyzed side slightly blunted, when compared with the rest of the body, where it was normal. The gastro-intestinal and uro-genital tracts were normal, as well as the heart.

The history of the patient did not reveal anything that could help the diagnosis. Her father died from some operation, the mother was and is well, has besides the patient another healthy child six years old, while two children were aborted long after the patient was born. The patient never was sick before and was feeling perfectly well before the attack. Absence of disturbances of sensibility, paresis of the lower portion of the face, the completeness of the paralysis, the presence of Babinski's sign—all this spoke for an organic lesion in the brain and against hysteria. In the latter there can be demonstrated absolute

*Erb: Diseases of the Nervous System, in Vol. XII, p. 483 of Ziemssen's Cyclopedia (American Edition.)

loss of sensibility confined to the paralyzed side,* the paralysis occurring only in some single muscles of the limb, but not in the entire extremity;† Babiniski's sign is absent in hysteria with such a frequency that Babiniski insists on its presence as a positive proof of organic lesion of the brain, while its absence in the hemiplegia strongly speaks for hysteria.‡ The young age, the absence of any affection of the heart that should suggest embolism of the median cerebral artery, spoke for thrombosis of a branch of art. cerebialis media (the lenticulo-striate branch of lenticular artery which is a branch of art. cerebialis media), namely of that branch that provides the large ganglia (n. lenticularis, n. candatus and the upper portion of the internal capsule). The thrombosis produced an interruption in the left pyramidal tract (caps. interna) and resulted in the complete right-sided hemiplegia. Though I could not find syphilis either in the patient's history, or in her parents, I had to diagnose the case as a probable syphilitic endarteritis of arteria cerebialis media, which was gradually getting narrowed, and then suddenly occluded, thereby causing the apoplectic attack. Hemorrhage, could of course, produce the identical symptoms, but the young age speaks against hemorrhage, while to clinically distinguish a case of thrombosis from that of a hemorrhage is often quite impossible. Prof. Nothnagel says that all attempts to differentiate an apoplectic attack due to thrombosis or cerebral hemorrhage proved unsuccessful.¶ Thrombosis of specific origin seemed very probable, and I at once administeredunctions of unguentum hydrarg. cinerei 4.0 daily to be applied as in the previous case, and 6.0 daily of potassium iodide. On the fourth day the dead feeling in the paralyzed hand started to give away to parasthesiae, and during the next two days she could, using some effort, close the right hand into a fist and open it. Such experiments with flexion and extension of the paralyzed hand used to make the patient tired, but after a short rest she could at will move the fingers again. The movements became wider and more free during the next few days, while some life and movement also appeared in the arm and in the lower extremity. She could stand up, but walking was still impossible. The improvement from the eleventh day of the treatment was rapidly progressing, the patient accordingly grew more cheerful,

and during the fourth week she could walk unaided and make all kinds of gross movements with the upper limb. She could sign her name, but the letters bore the trace of unsteadiness and tremor in the fingers. Altogether she received thirty frictions of blue ointment, which she bore well, no stomatitis having developed, which I tried to prevent by making her rinse the mouth and gargle with 2% solution of potassium chlorate. Potassium iodide was given in 6.0 daily doses for four weeks more, and her recovery was so complete that the patient could resume her daily work after two months from the beginning of her sickness. In this case, as in the previous one, there could not be demonstrated syphilis in the history, and the specific treatment proved, nevertheless, most successful.

The third case I am going to report just for contrast. The patient, a man 52 years of age, has been suffering from severe headache for the last fourteen months. The exact localization of the headache is not given in my notes, and I do not remember if the headache was confined to one particular portion of the skull. It did not increase in the evenings, or during night, did not cause any vomiting or disturbances of vision. Ophthalmoscopic examination of the eyes was not made as I have seen the patient in most distressing environments. Simultaneously he was suffering from tonic-clonic convulsions of the right half of the body. The convulsions always started with clonic spasms in the right arm, spreading to the right half of the face and then to the lower limb. He could stop the convulsions by firmly tying the forearm. Consciousness was never lost, but the patient always felt tired after the "spells." These used to visit the patient, at the beginning, once a month, but gradually became more frequent, so that at the time I have seen him, August 9, 1906, they used to appear every day, and even several times a day. By that time the right arm was paralyzed, flexed in the forearm, rigid, while the lower extremity and the right lower half of the face were in a state of paresis. The reflexes on the paralyzed side were highly exaggerated, ankle clonus and Babiniski present, no abnormalities on the part of the cranial nerves (with the exception of the above mentioned paresis of the lower branch of the facial nerve on the right side), no disturbances of sensibility, or on the part of the kidneys, heart, lungs and gastro-intestinal tract.

This case was that of Jacksonian epilepsy, due, perhaps, to a tumor. Syphilitic partial epilepsy runs in the same manner, but as Charcot pointed out* there is always loss of

* J. M. Charcot, *Clinical Lectures on Diseases of the Nervous System*, Vol. III, p. 403, London, 1889.

† Charcot, l. c. p. 403.

‡ Babiniski: *Du Phenomene Des Orteilis et de Sa Valeur Se miologique* (La Semaine Medicals, 1898, pp. 321-322.)

¶ H. Nothnagel: *Occlusion of the cerebral vessels*; in *Ziemssen's Cyclopaedia of the Practice of Medicine* (Vol. XII of the American Edition, p. 207.)

* Charcot: *Lectures on Diseases of the Nervous System*, Second Series, Transl. by J. G. Sigerson, London, 1881.

consciousness, which in our case was always preserved. There, of course, could be a syphilitic gumma on the convexity of the brain, producing symptoms of irritation of the cortex, but the history absolutely did not show any syphilis, the patient having been always strong and well, and his wife never aborted, all her children being alive and healthy. Nevertheless, I administered a specific treatment along the lines mentioned in the previous cases, and internally gave him pot. bromati and pot. iodati aa 6.0, aq. dest. 120.0. S.: One tablespoonful every two hours. The treatment was conducted for fifteen days, when I recommended an operation, because the patient's condition grew worse, he became completely paralyzed and the headache became unbearable. The developed complete hemiplegia did not differ in anything from a capsular hemiplegia, and without knowing the history of the patient it was impossible to say if in this case the hemiplegia was due to cortical or subcortical lesion. The operation was performed a few days later in Cook County Hospital by Dr. Schroeder. A large bony flap was excised, but no tumor could be demonstrated, and the patient a couple of days later died. A post-mortem showed a subcortical glioma of the brain.

In many cases operative treatment of cerebral lesions due to tumors or other removable lesions gives excellent results, and it should always be resorted to, if possible, especially if the specific treatment proved useless.

457 So. Center Ave.

PNEUMONIA.—The three great points in pneumonia are to relieve congestion, maintain intestinal activity and cleanliness and improve metabolism. Systemic antiseptics are also indicated. The man who uses calcium sulphide, aconitine, veratrine and digitalin (Abbott's) "defervescent compound," the sulphocarbolates and nuclein cures his cases, frequently aborting them within a few days.—Clinical Medicine.

INTERNES WANTED IN INSANE HOSPITAL.—The United States Civil Service Commission will hold examinations June 13 and 14, at the usual cities throughout the United States, to supply medical internes in the Government Hospital for the Insane, Washington, D. C. This examination is open to men who are citizens of the United States, aged 20 years or over, and graduates of reputable medical colleges. Applicants should apply at once to the commission at Washington for application form 1312.

It is not place, but love, which makes neighborhood.—Christopher Wordsworth.

TO GIVE AN ANESTHETIC.—"To give an anesthetic properly is all one person can do, and he who undertakes to learn surgery at the same time makes a serious mistake. It has been my privilege to instruct several in the administration of anesthetics, and I must say that nurses become the most proficient in this line of work. They do not aspire to be either a surgeon or an assistant surgeon. Hence it is not difficult for them to give their undivided attention to the anesthetic. I am sure that the time is not far distant when nurses will be looked upon as best fitted for the administration of anesthetics. One derives little or no benefit from text-books, and while one should be competent in the theoretical part of this important work there is nothing so helpful for the anesthetist as the hard school of experience."—Alice McGraw, Mayo's anesthetist.

TO REMOVE TATTOO MARKS.—Variot, of Paris, proceeds as follows "Apply under antiseptic precautions a concentrated solution of tannin to the skin and work it in as in tattoo operation. Then rub skin with pencil (or solution) of silver nitrate until the tattoo marks stand out as black points on the silver tannate. Excessive fluid should be removed; the surface turns black and moderate inflammation follows. In fourteen days the eschar drops off, leaving a red superficial cicatrix which fades in seven or eight weeks." This plan is safe and sure—but painful and tedious. Ordinary slight tattoo marks (powder marks, etc.) may often be removed by pricking in peroxide of hydrogen. Another plan is to tattoo well over mark with needles dipped in a solution of chloride of zinc thirty parts, distilled water forty parts. Eschar drops in two weeks. Then dress area with simple cerate. The fact that the insoluble substances which are used in tattooing become encapsulated explains the difficulty experienced in their removal. Under the microscope excised portions of tattooed tissue show large particles of pigment situated part in the corium, but more generally by the subcutaneous connective tissue itself. In the method by electrolysis the needle is attached to the negative pole of a battery with a current of from two to ten milliamperes and inserted at various points about the periphery of stained area till reaction is marked enough to insure destruction of involved tissue. The dry superficial eschar falls in a few days and the process may be again employed over the adjacent skin.—The American Journal of Clinical Medicine.

THE UTILITY OF DISTENDED AND DRIED SPECIMENS OF VISCERAL ANATOMY.

BYRON ROBINSON,
CHICAGO.

SURGERY is the father of anatomy. Dissection on the dead or living creates practical anatomy. Distended and dried specimens creates instructive anatomy. Corrosion anatomy is the most accurate anatomy. In modern times, in the blooming of visceral surgery it requires all methods and especially the best of methods to impress the students and physicians with practical anatomy of viscera and their relations. Frequently erroneous diagnosis are chiefly due to the lack of knowledge of visceral anatomy and their

from distended dried specimens of the ureter (i.e., the ureter proper, ureteral pelvis and calyces). By distending the ureter its distinct form is evident. I distended over 200 ureters of man and animal with fluid, air, red lead and starch, liquid paraffin. I found that in man the form of the ureter is practically constant. It consists in general of three constant isthmuses (constrictions) and three dilatations (spindles, reservoirs).

The proximal isthmus is located adjacent to the distal pole of the kidney. The middle isthmus is located at the crossing of the iliac arteries by the ureter, and the distal isthmus is located in the parietes of the vesica urinaria. The proximal ureteral reservoir consisting of the calyces and ureteral pelvis is located within the renal hilum. The middle reservoir or spindle is located in the lumbar region, on the psoas muscle. The distal reservoir or spindle is located in the lesser pelvis.

When the form of the ureter is distinct it is plainly evident that the proximal ureteral isthmus may become obstructed by small calculi or by limited flexion of the ureter. The distal ureteral isthmus located in the bladder wall is of limited lumen obstructing calculus with facility. Hence in the subject of usual ureteral form the distended dried specimens are instructive, especially as regards the lodgment and passage of ureteral calculus. Fifty per cent of calculus become lodged and obstructed at the proximal isthmus. Also the distended dried form demonstrates that flexion on the constricted proximal ureteral isthmus might induce periodic hydro-ureter. Hence the form of the ureter—with its three isthmuses, proximal, middle and distal: dilatations, proximal, middle and distal—is theoretically and practically demonstrated.

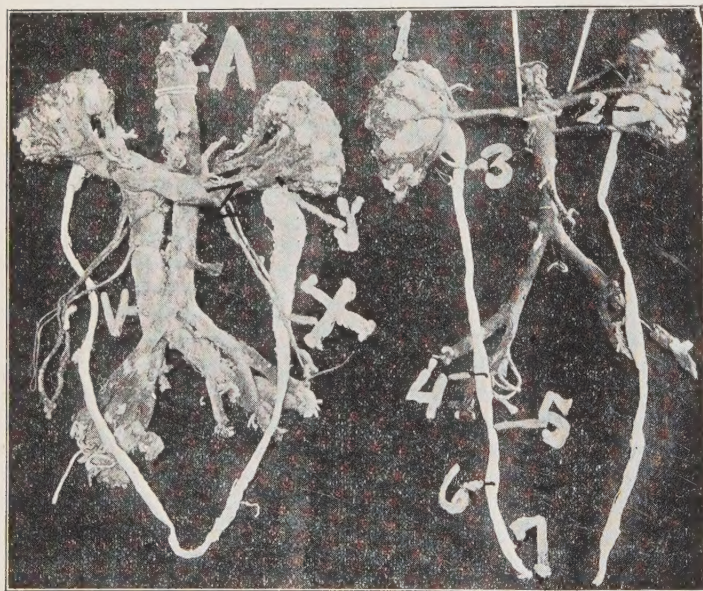


PLATE I. Represents injected, dissected and dried specimens of ureters and vessels. Photography defectively produces them. No. A (left). Presents distended and dried vessels and ureters. The ureteral pelvis and calyces (occupied by paraffin) present beautiful in the original specimen Z.X.Y represent the utero-venous triangle (of Byron Robinson) which is a constant anatomic structure especially disturbed in splanchnoptosis (nephroptosis). On the right side the spermatic vessels are double. No. 1 presents distended vessels and ureters in their natural course. Observe the form of ureters as to isthmuses and dilatations, viz., (3), proximal; (5), middle; (7), distal isthmuses—(1) and (2) calyces and pelvis; 4m lumbar; 6, pelvic dilatations.

relation, and it is absurd to expect general practitioners to know anatomy without practical and theoretical study which we know in general they do not pursue. Visceral anatomy should be steadily pursued during the junior and senior year. In this communication I will present the different kinds of viscera from which excellent and practical views may be learned from distended and dried specimens.

THE URETER.

uch practical knowledge may be gained

and its three

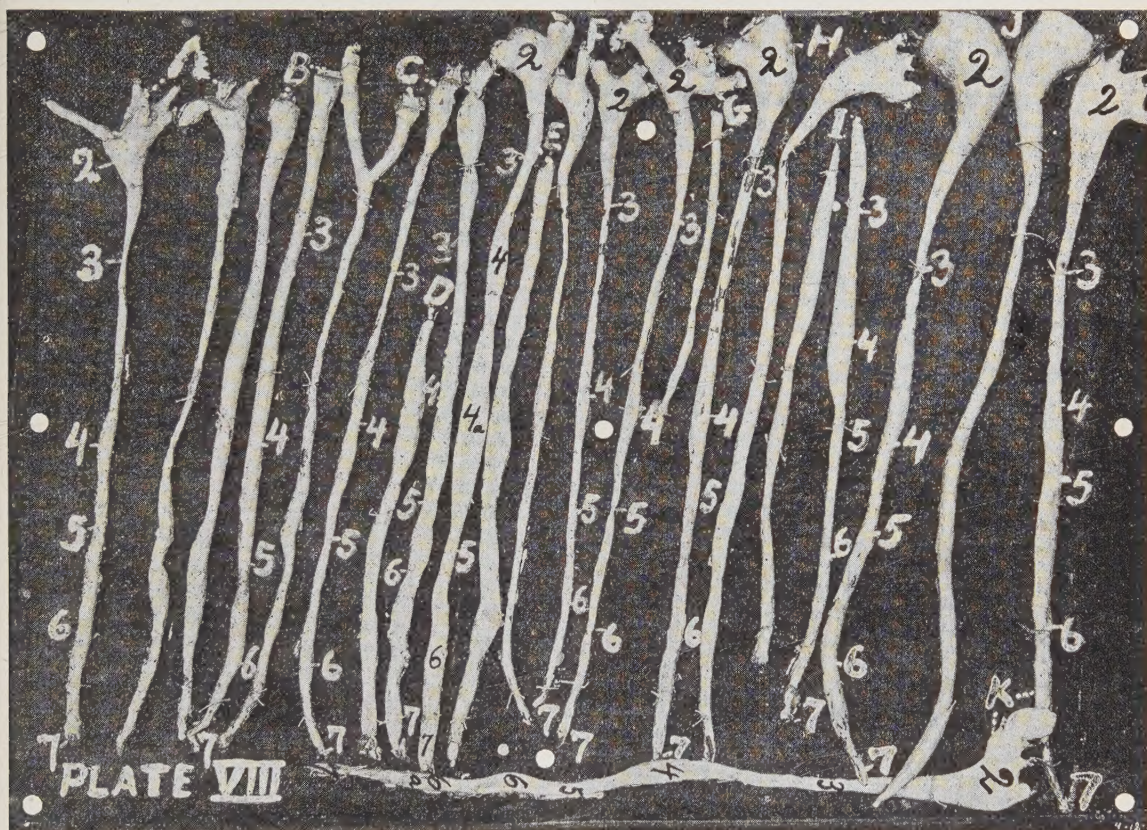
TRACTUS INTESTINALIS.

Much excellent and practical knowledge may be rendered by demonstrating distended and dried specimens of the intestinal tract. Especially the form is instructive as well as the appearance of the circulation. The best methods to demonstrate the appendicular circulation is by injecting the superior mesenteric artery with red lead and starch,

and distend a segment of the ilium and appendix, cecum and a segment of the right colon, dissect the vessels and allow the specimens to dry while distended (see Fig. 1). The variation of the appendicular arteries in number, origin, dimension, length, distribution and anastomosis will astonish even the glib appendicetomist. In the illustrations of the subject accompanying this article there is one appendicular artery arising from the dorsal ileo-cecal artery (1) to supply the free appendicular end. Also one appendicular artery arising from the ventral ileo-

BILIARY DUCTS.

Excellent instruction may be derived from the distended and dried biliary ducts one can study the dimension, form, contour, length, spirality, valves, diameter. I suggest that distended dried specimens preserve best when varnished. However, if one wishes to photograph the specimens it is better to paint them white and place them on a dark ground. I have classified the biliary ducts and pancreatic ducts into landmarks for facility of clinical study. A landmark is a



URETERS.

PLATE VIII. Distend, dried, ureters. 22 specimens. The intention of this illustration is to demonstrate the form of the ureter—its 3 isthmuses and 3 dilatations. 3, 5 and 7 represent the proximal, middle and distal isthmuses. 2, 4 and 6 represent the proximal, middle and distal dilatations.

cecal artery (2) to supply the middle portion of the appendix and also a third appendicular artery arising from the dorsal ileo-cecal (5) to supply the basal portion of the appendix. The appendicular arteries from the dorsal and ventral ileo-cecal arteries anastomose by distinct branch considerably removed from either origin. S, ileo-cecal artery. B, mesenteric branch. Distention of the ileum and cecum not infrequently reveals marked arterial loops.

point for consideration—anatomic, physiologic, pathologic. I assume five important landmarks in the pancreatic and biliary ducts, viz.:

- I. Pelvis of gall bladder (cholecystitis pelvis). Hartman's pouch.
- II. Cystic duct (ductus cysticus).
- III. Intrapancreatic segment of the bile duct.
- IV. The relation of the vater's ampulla to the termination of biliary and pancreatic ducts.

V. Single or multiple terminations of the pancreatic ducts.

On the above five landmarks of the biliary and pancreatic ducts depend many clinical phenomena with properly prepared distended and dried specimens the above five landmarks may be studied. In the incomplete specimens (Plates II and III) certain landmarks only may be studied.

I. Pelvis cholecystitis or Hartman's pouch may be studied to advantage in distended and dried specimens. The pelvis of the gall-bladder is cone-shaped. It harbors calculus with facility and some calculi cannot be dislodged without fracture; The gall-bladder pelvis is the location of or engagement of calculus in the orifice of the cystic duct. One of the best examples of Hartman's pouch is (X) plate II. Another is (H) plate II.

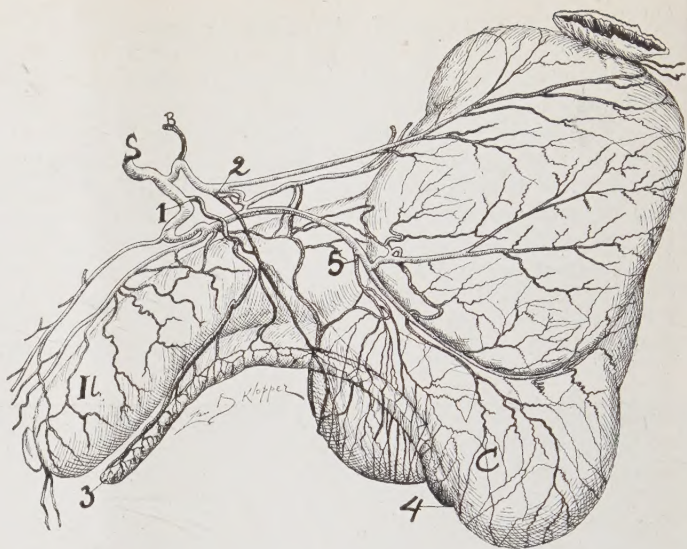


FIG. 1. Distended, dried cecum, ileum and appendix with arterial infection. Dorsal view. The interest in this illustration lies in the arterial supply to the appendix. S, ileo-colic artery. 1, (primary) appendicular artery arising from the dorsal ileo-cecal artery, supplying the free end of the appendix. 2 (secondary) appendicular artery arising from the ventral ileo-cecal artery supplying the middle segment of the appendix. 5 (tertiary) appendicular artery arising from the dorsal ileo-cecal artery supplying the base of the appendix.

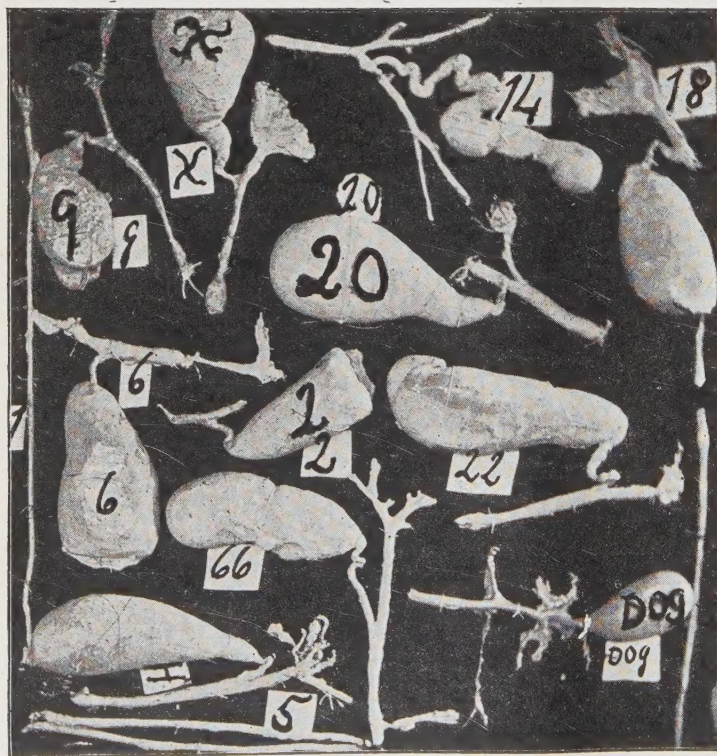


PLATE II presents several distended and dried specimens of the ductus biliaris. The study of form, dimension, spirality, valves, position and relation is facilitated. No. 14 is that of a mountain lion and one other specimen is that of a dog (marked). With the exception of four ureters the remainder is of a man's biliary ducts. For spirality and valves study the cystic duct. See Nos. 22, 66, H, 9 as marked examples. The cholecyst presents a variety of forms. See H, 22, X, 6. Observe the variation of the entrance of the ductus cysticus in the ductus hepaticus, see Nos. 20, 66, X, 22. Note the form of the choledochus.

II. The cystic duct can be excellently studied in distended dried specimens. Its average length ($1\frac{1}{2}$ inches), diameter ($\frac{1}{2}$ inch), Heister's valve (7), axial rotation (2) are of extreme interest especially in regard to calculus and catarrhal processes. The cystic duct possesses a variation of three times its average length ($1\frac{1}{2}$ inches), four times its average diameter ($\frac{1}{2}$ of an inch), $1\frac{1}{2}$ times its average number of valves (7) and a variation of its spirality.

These anatomic facts explain the excruciating pain during the passage of calculus. The most typical example of spirality is No. 9 of both plates where a match lies within the lumen of the cystic duct spiral. The mountain lion No. 14 in plate II is remarkable for its spirality.

No. 6, Plate II, presents a cystic duct of limited length, diameter and numerous marked Heister's valve.

Nos. 20, 22, 66 and H in



PLATE III presents distended and dried specimens of the ductus biliaris (except 20 which is a ureter to present constrictions and dilations.) The ductus biliaris may be here studied from dimension, contour, relations, spirality, valves, diameter, length, position, constrictions, dilations. The form of the choledochus may be observed typically in Nos. 18, 13, 3, 14, 15. For valves on spirality observe the cystic duct, especially No. 9, where a match lies within the lumen of the cystic duct spiral. Also a similar condition exists in No. 9, Plate II.

Plate II present marked spirality on valves in the ductus cysticus.

Nos. 18, 9, 11, of Plate III present marked valvular and spiral conditions.

The distended, dried ductus cysticus bisected longitudinally presents Heister's valves with marked prominence.

III. The intrapancreatic segment of the common bile-duct present frequently a spindle-shaped dilatation. See Nos. 13, 19, 18, 14, Plate III and No. 20, Plate II. The intrapancreatic segment of the common bile duct is significant pathologically—not in distended dried specimens—as it may infect the caput pancreaticus when hepatic duct infection exists.

IV. The relation of Vater's ampulla to the termination of the hepatic and pancreatic ducts may be studied by the aid of distended and dried specimens. Liquid paraffin or celloidin are the best agents. By injecting these liquid materials first through the common bile duct from the junction of the common bile duct and cystic duct to Vater's conical ampulla and at the same time producing obstruction of Vater's ampulla, the same may become well distended with congealed material. Second, incise the ductus pancreaticus through the corpus pancreaticus, insert a canula and inject toward the termination of the pancreatic ducts to the duodenum, obstructing the point of exit until the liquid material becomes congealed whence the periductal tissues may be dissected presenting not only the form of Vater's ampulla, but also the form of the termination of Santo-

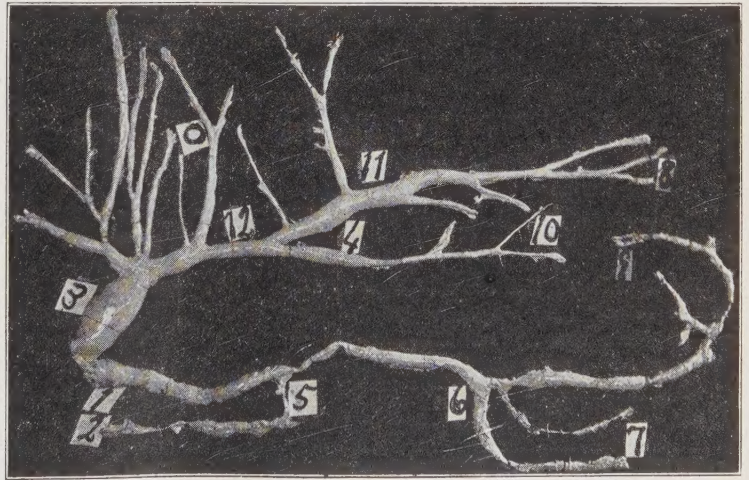


PLATE IV presents a distended and dried specimen of the ductus biliaris and ductus pancreaticus of a horse. 3, ductus choledochus (no cholecyst exists in the horse, however, common bile duct is extraordinary large; e. g., observe the dilatation at 3.) O, lateral bile ducts. 12, main, hepatic duct. At 4 the main hepatic duct bifurcates to attend different hepatic lobes. 11, lateral biliary ducts as are 10 and B. 1, ductus pancreaticus (Hofman-Wirsung duct) having an exit on the floor of the giant Vater's ampulla. 6 and 7 lateral pancreatic ducts. 9 duct of cauda pancreatica. 2, ductus accessorius pancreaticus (Santorini's) with an exit, separate and independant in the duodenal mucosa. 5, point of anastomosis of the ductus pancreaticus and ductus pancreaticus accessorius.

rini's duct. The result is after numerous injections (we performed some 50) that usually the biliary and pancreatic ducts exist on the floor of Vater's diverticulum separately and independently.

V. Second that there are present two pancreatic ducts, which in two-thirds of subjects are functional. The duct of Santorini may be the most constricted in its lumen when it terminates in the duodenal mucosa. For landmarks IV and V a lens magnifying 25 diameters is requisite, but it reveals wonderful arrangements in anatomy and physiology not observed in ordinary standard anatomical text-books.

MEDICAL MISCELLANY

THE Japanese government made a single purchase of one hundred thousand pounds each of carbolic acid and corrosive sublimate for use during the war with Russia. Among the other drugs they used were 100,000 ounces of quinine, and they also bought all the bismuth subnitrate and sodium salicylate available. It is noteworthy also that each soldier was required to take one beechwood creosote pill per day for the purpose of preventing dysentery.

WHAT CHILDREN SHOULD BE TAUGHT.—Children should be taught the following things: That teasing is a positive crime. That they must eat bread before pastry. That bedtime is not a "movable" hour. That they must speak politely to the servants. That weeping over bruises is unworthy of sturdy beings. That they should not appeal to one parent from the decision of the other. That punishment follows in the wake of prevarication and of deceit more swiftly than it follows actual mischief. That it is in bad taste for them to tell all that they learn of the neighbors' domestic arrangements through playing with the neighbors' children.—Health.

FOR A FEDERAL HEALTH BOARD.—The committee of one hundred appointed last June by the American Association for the Advancement of Science to further the project of founding a Federal Department of Health, held a meeting in New York on April 19. These vice-presidents were elected after Prof. Fisher had been elected president of the larger committee: President Eliot of Harvard, Felix Adler, Dr. William H. Welch, Dr. Lyman Abbott, President Angell of the University of Michigan, Jane Addams, Andrew Carnegie, Archbishop Ireland, Judge Lindsay of the Juvenile Court of Denver, and John D. Long, ex-Secretary of the Navy.

INDIANA STATE TUBERCULOSIS FUND.—The Indiana Legislature appropriated \$30,000 for 500 acres of land as a site of a hospital for the treatment of incipient tuberculosis. A commission of five members appointed by Governor Hanly will select the site, and then the next legislature may begin the buildings. A fixed quota of incipient patients may be taken from each county.

THE FATE OF CALOMEL IN THE BODY.—Researches indicate that the acid of the stomach has little or no effect upon calomel. Nesmer regards pancreatic juice as the most potent factor in effecting solution of the drug. The kidneys, liver and large intestine retain portions of the calomel for a considerable length of time. As to the form of mercuric compound formed from the calomel we are not enlightened.

HOLLAND has a unique plan of raising money for the national campaign against tuberculosis. There has been issued a series of postage stamps, costing fifty per cent more than the ordinary stamps of similar denomination, the excess in cost being devoted to the anti-tuberculosis crusade and the establishment of open air sanatoria. In this way there is an ever-present reminder before the people to help in this splendid cause.

RAPID EATING.—There is a prevalent idea that slow eating is favorable to digestion, but this is often fallacious. The important point is not that we eat slowly or fast, but that when we do eat we chew with energy. Of course, where the haste is due to some mental anxiety this may injuriously inhibit the secretions. Slow eating begets a habit of simply mulling the food without really masticating it, whilst the hurried eater is inclined to swallow his food before proper mastication. Hence hurried eating is bad, but rapid mastication, if vigorous, may be advantageous.

ST. LOUIS SKIN AND CANCER HOSPITAL.—According to the first annual report of the St. Louis Skin and Cancer Hospital, which institution was founded on July 1, 1905, during the eighteen months between its foundation and January 1, 1907, 117 inpatients and 674 outpatients were cared for. The equipment of the building at present occupied by the hospital cost some \$5,000, and its upkeep has cost about \$10,000 more. The institution is at present in the experimental stage, its support for a period of five years having been guaranteed by about 150 original subscribers; it is hoped that by the end of the experimental period, the hospital will be on such a sound footing, and have justified its existence so fully, that a move to more suitable quarters can be effected.

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OFFICIAL TRANSACTIONS.

PREMATURE PUBERTY — HISTORY OF CASE.

JOHN MCHALE DEAN, M. D.

ST. LOUIS, MO.

IN presenting this boy, who apparently seems a young man, I feel I may interest the society in a case that to me is remarkable.

This boy is 6 years of age, with a physical development of a young man 16 or 17 years of age. His face and head are large, slight growth of hair growing on his upper lip, and in the region of the pubis the hair is as abundant as an adult's. The face is covered with comedones. The penis is large, about four inches in length. The right testicle is about the size of an egg, hard and firm to the touch, and showing only a slight presence of an epididymis. The left testicle is normal (6 years of age.) The muscles of the entire body are exceptionally developed. His voice is low and coarse. Erections of the penis are frequent, but the presence of emissions can not be ascertained.

His father is dead, having died from a meningeal trouble following middle ear supuration.

DISCUSSION.

Dr. Louis Rassieur.—I would ask the doctor whether that testicle became enlarged before the young man matured or afterward.

Dr. Frank Fry.—I see the point of the doctor's question, and it is a very pertinent one. I hardly think it probable that the mere activity in the testicular tissue would be responsible for a thing of this kind.

Dr. Dean.—I am not certain. I have an idea that probably the condition of the testicle was just noticed accidentally. I am hardly able to say which appeared first.

Dr. Rassieur.—I found that the testicle itself was not enlarged, but that the epididymis was enlarged, therefore I think it is either a tumor or some specific infection.

Dr. Dean.—I think I will stand by and await developments. In fact, I am at a loss to know what to do in a condition of this

kind. Some one has suggested the thyroid gland, but I do not see what effect that would have.

Dr. Fry.—I do not think the patient is a cretin.

OMENTAL TUMOR.

JOHN MCHALE DEAN, M. D.

ST. LOUIS.

IN presenting this patient before the society I trust I may arouse a liberal discussion of a case that has been of exceptional interest to me, and one whose diagnosis is somewhat doubtful.

Patient, Mr. S., is 46 years of age, married and the father of two apparently healthy children. The older is 12 and the younger is 8 years of age. He has been addicted to the excessive use of liquors up to four years ago, but since that time has used liquor moderately. Smokes moderately. Twenty-five years ago patient had a sore on his penis, which lasted for three weeks. He consulted a physician, who gave him anti-luetic treatment. He does not recall ever having had any eruption, but has had mucous patches in his mouth. No other symptoms of lues could be ascertained.

Family History.—Father died of typhoid fever, mother still lives and apparently in good health; one sister died of diphtheria, one of croup in childhood, and a brother died of typhoid. No history of tuberculosis could be found either in his family or relatives.

Present History.—Patient first had his attention drawn to his condition eleven months ago, when he noticed his abdomen began to swell. There was no pain or discomfort complained of. He consulted his family physician, who referred him to me to be tapped for ascites.

Physical Examination.—Patient slightly anemic, adipose tissue poorly developed; no icterus noticeable. Slight enlargement of the inguinal glands; no other adinopathy marked. Heart and lungs normal. Pulse 84, temper-

ature normal. Liver dullness decreased, abdominal superficial veins enlarged and tortuous. Spleen enlarged. Just above the umbilicus is an enlarged gland which the patient tells me has decreased in size when under the iodides. The umbilicus is prominent and shows a slight hernial protrusion. The abdominal cavity is filled with free fluid and palpation shows a number of masses varying in size from an English walnut to the size of a cocoanut. Prostate normal. Blood, hemoglobin 85 per cent, red cells 4,500,000, white cells 6,000. Urine shows nothing abnormal with the exception of an excess of indican.

June 12th. I tapped the patient and obtained two gallons of fluid. The fluid was tinged with blood and readily coagulated. The fluid was injected subcutaneously and intra-peritoneally into guinea pigs by Dr. Fisch, but with negative results as far as tuberculosis was concerned. In August I tapped patient again and obtained about the same amount of fluid. This fluid had the same characteristics as the first, except that it contained a large number of small bodies, the size and physical appearance of which closely resembled sago granules. A number of these granules were examined by Dr. Fisch, who pronounced them portions of an adeno-carcinoma.

On October 9th I performed an exploratory laparotomy and found the omentum entirely involved in a new growth. It was freely movable, and only on close scrutiny omental tissue could be made out. The abdominal glands were enlarged, and could be felt running up to the lesser omentum. The liver was small in size, but showed no marked change. A section of the omental growth was removed, and given to Drs. Fisch and Thompson for pathological examination. The report of same I will leave to these gentlemen.

At the operation I allowed all the fluid to escape and sewed up the abdomen without drainage. The recovery was uneventful.

My patient did not have a return of the fluid for six weeks, since which time it has gradually reappeared. He continues to feel well, appetite is good, suffers no pain, and his bowels move regularly. His weight is 135 pounds, and he weighs the same now as when he was first taken ill.

DISCUSSION.

Dr. Carl Fisch.—My report on this case must be very short. At the beginning of this case it was a question of diagnosis, and from many of the symptoms and the condition of the patient we thought we had to deal with a tuberculous peritonitis, but our investigation in that direction revealed nothing pointing to that condition. The peritoneal

fluid was remarkable for the immense amount of blood and mucus. It showed a great number of leucocytes, 90 per cent being small mononuclears. Guinea pig inoculations resulted negative as far as tuberculosis was concerned. In a second specimen little globular gelatinous masses were seen, microscopically recognized as a gelatinous adeno-carcinoma. In those portions well preserved the columnar cells of the growth were very much of the character of the intestinal epithelium. The tissue removed in September was more unfavorable. It consisted of a fibrous network, the meshes of which were filled with a curious substance. In some cases these cyst-like spaces were lined with columnar cells. The malignant character of the tumor could be demonstrated in all directions. There is no doubt about its being gelatinous adeno-carcinoma. Epithelial tumors of the omentum are well known. A number of cases have been reported. The most frequent of them is this gelatinous adeno-carcinoma. In all of them the epithelium resembles the intestinal mucosa. It was formerly thought that the occurrence in the peritoneum and in the omentum was due to the misplacement of embryonic tissue; in a number of cases, however, the direct derivation from the intestinal mucosa has been demonstrated by finding a small primary tumor in the intestinal wall that penetrated the mucosa and then disseminated itself over the peritoneum and the omentum. If that is the origin in the present case I do not know. The fact that this patient in spite of the presence and growth of such a carcinomatous tumor has retained a good condition is due to the fact that of all carcinomata these gelatinous carcinomata are the least inclined to metastases. They grow slowly. While this tumor looks large, you would find, were you to reduce it to the number of cells only, that it would correspond in size to a normal ovary. The case was interesting to me because of the possibility of making a diagnosis from the peritoneal fluid.

Dr. R. L. Thompson.—Last October I received a piece of tissue about the size of a hazelnut. It was soft, contained a number of cysts filled with greyish white gelatinous material. I made frozen sections and found merely a mass composed of cysts in a somewhat loose connective tissue stroma. Most of them were devoid of epithelium lining. My first idea was that it was simply a multilocular cystoma, but further study of the specimen showed that in several of these cysts there was piling up of the epithelium and there were patches of epithelium that were irregular and suggested malignancy. I

was not fortunate enough to get such a specimen as Dr. Fisch's. I would like to emphasize the extreme difficulties of microscopical diagnosis from small pieces of a large tumor, especially where perhaps the top part of the tumor is cut off. Perhaps we may not receive any of the active growing part of the tumor at all. In such a case you can only report on the specimen you have. Hence it was extremely difficult to get at the nature of the growth. Undoubtedly the tumor is of the type which Dr. Fisch suggests. Another form of tumor which perhaps it would not be out of place to discuss here is the development of various forms of cystoma which are sometimes found in the peritoneal cavity. They arise only from the liver, kidneys, testicle, ovaries and breast. They may give rise to tissue varying from the simple cyst to malignant tumors, such as that presented here tonight by Dr. Harris.

Dr. Rassieur.—I would like to know whether Dr. Dean had made a Koch injection in this case.

Dr. Dean.—No.

Dr. Rassieur.—What was the specific weight, Dr. Fisch?

Dr. Fisch.—The specific weight was 1017.

Dr. Rassieur.—Now, if it is a malignant tumor, I don't think there is much the surgeon can do in a case of that kind, because the tumor is so diffuse that it is absolutely impossible to try to operate upon it. It makes one think of Ribbert's last words on tumors, wherein he says the surgeon's aid has not been definitely established in such a case. He further states that we must look forward to the time when the medical man will find something that will have a specific action on the growth, for certainly the knife is of no avail in many cases.

Dr. Howard Carter—I would like to compare this case with a similar one which I saw a few years ago. The tumor was located between the posterior wall of the bladder and the anterior wall and fundus of the uterus, the intervening space being filled up with the tumor mass, which apparently originated in the bladder. The posterior wall of the bladder was friable, of a pale greyish color, deficient in blood supply and hypertrophied to a thickness of about three-fourths of an inch. The abdomen contained a large amount of clear amber colored ascites, in which floated innumerable almost transparent bodies about as large as sago granules. All of the abdominal viscera as well as the diaphragm and the parietal peritoneum were covered with patches

of new growth. The appearance of the patches was pale and moderately translucent, they were coarsely granular on the surface and irregular in outline, the size varying from that of a sliver quarter of a dollar to that of the palm of the hand, the average thickness being about one-third of an inch. The development of the condition probably did not exceed a year, there was severe and constant pain, but little or no cachexia. The patient succumbed to shock following exploratory operation. Microscopical examination showed intense activity of cell development with exaggerated mitosis in the granular masses, the more substantial portions of the tumor showed general mucoid degeneration.

DISCUSSION OF THE DIAGNOSIS.

Dr. Elsworth Smith.—I would rather modify that a little and make it, what lesson should we learn from this case in making the diagnosis? As I understand it, the diagnosis has already been made. It is an extremely interesting case and teaches a great lesson. This man after having this malignant trouble over a year weighs what he did then, the blood examination shows no disturbance, the man has had no pain, he eats and sleeps well. When a patient has had malignancy in the abdomen over a year we would think of pain, cachexia, loss of weight and strength, and we certainly don't think of a favorable prognosis. So that without the evidence of the microscope and seeing this patient mighty few of us would be willing to make a diagnosis of malignant disease. From the examination of the patient, that is, from the physical examination of the abdomen, the impression I would get would be of a retroperitoneal affair. I have in mind a case in which the physical signs were like those in the present case. The patient was a man over 70 years of age. He presented himself at Mullanphy Hospital with a massive hard tumor in the umbilical region extending up toward the epigastrium. He had deep-seated, persistent pain. This was the first symptom and had continued through all the trouble. This, together with the loss in weight and the cachexia were the only symptoms. We had to make the diagnosis by exclusion. We found the stomach was not involved, the colon in front of the tumor was not involved and the urine was negative. The diagnosis by exclusion was a retroperitoneal growth. It was doubtful whether it could be sarcoma at that age, although some have been reported. We found a large tumor which had sprung up in the retroperitoneal space, encased both kidneys and extended down and filled the pelvis. It was a large round cell sarcoma.

But in that case we had all the evidence of malignancy. Another thing that would suggest itself clinically if we had not the evidence of Dr. Dean as to what was found pathologically, and that is, we might think of lues, and no doubt we would be tempted to give the man treatment along that line. Another peculiarity of this case is the localization of this thing to the omentum, it being so much more involved. Usually in such a condition we have a general carcinosis of the peritoneum. Certainly Dr. Dean is excusable for being puzzled until the pathologist made his report, for I don't see how the condition could have been diagnosed clinically, and I should be interested in having the ultimate result of a persistent and energetic course of anti-leucic treatment, for I must confess that the case forces on me a strong suspicion of its being of a specific nature, in spite of the microscopical diagnosis; and after all, in the ultimate making of a diagnosis, the results of the microscopic findings, must only be considered as part of the evidence, while the greater reliance must be placed on the clinical findings and their correct interpretation.

Dr. George Homan.—If the surgeon can do nothing and the physician throws up his hands, does the X-ray afford any hope in such a case? It does seem to be held out to some extent judging from the important effects of the X-ray in deep malignant disease, as gathered from a paper that was read before the American Medical Association in Boston last year.

Dr. Morfit.—I think I can say positively that there is nothing to be expected from the X-ray in the treatment of cavity cancers. There is not a case on record where it can be proven that the X-ray has had any effect. I have used the X-ray in liver and stomach cancers with absolutely no result. In one case of liver cancer I was able to cut down on the growth, expose it and get the direct effect of the rays on the growth. The effect of the X-rays on superficial cancer is positive in many cases, but we are not at a point where we can regulate the dose and say that in this case it will result in a cure, and that in another it will not. It is empiric, and if success follows its use we don't know why.

Dr. Rassieur.—The statements from the medical and surgical side seem so very gloomy. The man has had this trouble for a year and looks so very well. Professor Schauta had a case of the papillomatous type of malignant cystoma of the ovary and on the peritoneum, and all around were what seemed to be metastases. She also had an ascites.

Professor Schauta sewed her up, gave a very bad prognosis and the patient went home, out in the country, and was forgotten. About three years later she returned for another trouble and all the signs of malignancy in the tumor had disappeared. Schauta held this up as a very unique case. This makes us wonder whether some of these carcinomas do not get well of their own accord. That is a question that has been much discussed, especially in carcinoma of the stomach. There are several cases on record where examination was made by good men, and unless there was an error it was a case of carcinoma recovering.

Dr. Fisch.—Schauta's is not the only case. The first case reported was that of a carcinoma of the peritoneum in which the microscope established the correctness of the diagnosis and a laparotomy was done. The patient recovered. The action of the laparotomy seems in some cases to have the same effect that it is said to have in peritoneal tuberculosis. Possibly the fact of this patient having remained so well is the effect of the operation.

Dr. W. C. G. Kirchner.—This is an extremely interesting case, and it is certainly of value. It is easy to talk about these things after the diagnosis is made, but before the diagnosis is made the problem is entirely different. It is important for the surgeon to convince himself what the trouble is. Tumors of the abdomen are extremely difficult at times to diagnose, whether they be tumors of the stomach, intestines, pancreas, etc. Should one meet a tumor of the omentum, from the surgical standpoint it would seem this tumor should be removed, especially if free. A carcinoma removed from the body is better than if left where it is. A tumor of the omentum can be easily removed. I have removed large masses of omentum (fatty omental tumors), and the patients were none the worse for it. Malignant tumor of the omentum is very rare, and the surgeon ought to remove such tumor, even if there is doubt as to the condition. In general, all tumors should be removed when they can be easily removed, for they may grow or become destructive if left to themselves. We have a number of times operated on abdominal tumors that at laparotomy were pronounced malignant with improvement in the case. A year or two ago we operated on a case of suspected carcinoma of the stomach, and finding an unfavorable condition the operation was merely exploratory. The patient went away, and later fell into the hands of Dr. Mook, who reports that she is now apparently well. Tumors of

the pancreas, too, have come back to us apparently recovered after exploratory operation, but I doubt if these tumors were malignant. The character of the abdominal fluid is of importance. In tuberculosis the fluid we get is usually clear, but in malignant conditions it is dark and contains blood.

Dr. Smith.—In those cases where operation was done and malignant condition found and the patient recovered, was any part of the tumor taken for microscopic diagnosis?

Dr. Kirchner.—Unfortunately, no, but we did see cases that were inoperable improved after exploratory operation.

Dr. Dean, in closing.—I reported this case as doubtful. I think after you hear my reasons that you will bear me out. Dr. Thompson was of the opinion that the condition was benign, even two or three days ago he still clung to that idea. Dr. Fisch thought it was malignant from the start. Of course I could not risk removing a larger piece. I did not know how vascular it would be, and I don't know just how I might have checked the hemorrhage. Dr. Kirchner spoke of removing the tumor. Had he seen this case on the operating table he would have shaken his head. This tumor absolutely hooped the transverse colon and to remove it, it would have been necessary to remove the transverse colon also. If there was such a thing as grading a tumor as to its malignancy by its size, we would say this was very malignant, yet this gentleman's weight is what it was a year ago. A point to be considered is that under the iodides the glands became smaller. The patient is now on the iodides, and I still believe clinically that this may be a case of syphilis. The fact that this tumor is smaller than when operated on is undoubted, and that it is getting smaller under the iodides is also a fact, yet what relation there is between syphilis and malignancy I cannot say; but I hope some day to present this patient as having been cured under potassium iodide and mercury. I don't think any one would try to operate on this patient considering the involvement of the transverse colon. As far as the X-ray is concerned I must say I do not believe it is of any use in deep tumors. I have not had any result from its use. Speaking of tumors operated upon and pronounced carcinoma, and afterward recovering, I would like to mention a case. I operated on a woman of 38 years, in whom there was decreased hydrochloric acid, presence of lactic acid in the stomach washings, showing foul putrefaction. The patient was very weak. I opened the abdomen, explored the stomach and found a tumor adhering to the under surface of the liver and involving

the entire coat of the duodenum. I concluded it was a carcinoma, and that the only thing to do was palliation by performing a gastroenterostomy. This patient has gained 50 pounds in weight; is able to eat anything, and the tumor has disappeared in the course of a year, and still continues to feel perfectly well. I think now it was not a case of malignancy, but a case of callus duodenal ulcer. To be certain of the diagnosis of malignancy it is necessary to have clean cut microscopic specimens.

ONE of the healthiest spots in the world is the Island of Pico, in the Azores. It has a population of about 3,000. For 395 years it has not had a physician or a drug store, or a contagious disease. When residents become so old that they think it is time to die, they move to a less healthy place.

INDUSTRIAL DUSTS.—The American Institute of Social Service has received from Dr. Sommerfeld of Berlin a valuable antituberculosis exhibit for the department of industrial hygiene in its Museum of Security. There are forty-five specimens of different kinds of dust, mineral, animal, and vegetable, produced in various industries, and likely to be inhaled by workmen. The same number of photographs show the microscopical characteristics of these various dusts. Models in wax represent human lungs as they are affected by occupational dusts; other models show normal lungs for comparison, while still others show the effects of industrial poisons on the system. An advisory committee of the editors of the great technical papers has been organized to cooperate with the institute in the work of protecting life and limb in industrial workers.

SANITARY SLEEPING CARS.—The health authorities of the State of Texas have adopted and are enforcing a code of sanitary rules for the sanitation of railway cars which will insure to the traveling public immunity from many of the discomforts to which it is now subjected. Sleeping cars are to be kept so clean at all times that there is no possibility of the accumulation of dust or filth of any kind. A measure of the greatest importance is a discrimination between sleeping cars running within the State and those leaving the State for other states. The latter are not only subjected to the rigid rules of those within the State, but they are required to be fumigated thoroughly every second or third trip, according to the number of days which the trip occupies. If an infectious disease is found on board the car must be detached at the next station and disinfected before it is again used.—Medical Age.

THE MEDICAL FORTNIGHTLY

Issued Tenth and Twenty-Fifth of Every Month.

THOMAS A. HOPKINS,
Managing Editor.

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Editorial Rooms, Suite 319-321 Century Building, St. Louis.

EDITORIAL

So much has been said in the medical press and elsewhere in condemnation of the publicity given by the religious press, so-called, to the rankest of medical fakirs that no excuse for giving it further mention should exist;

The "Sky Pilot" and the Medical Fakir.

but with a few scattering exceptions the pointing out of the evil of their way has failed to effect reformation and many of these organs are really unfit to enter the home. The almighty dollar which comes from these questionable advertisements seems to outweigh any sense of moral responsibility with those who control this form of literature, and we are left to conclude, much as we regret doing so, that there is a definite cash value for which space and their influence can be bought. Not alone in their literature do our spiritual advisers show a weakness for the irregular and irrational, and for the profit which accrues therefrom, the sectarian clergy includes in its number the most prolific testimonial writers to be found. Ministerial testimonials to the rankest medical frauds and to the most enticingly dangerous of narcotic remedies have always been easily obtained and widely exploited. What these testimonials will carry in the way of religious influence now that the law makes necessary the labeling of drugs with the quantity of narcotic and poison entering their composition, remains to be seen, one would expect to see a rather undignified ministerial scramble to recover testimonials which may not look well in the new connection.

And again, our ministerial brother, or some of him, is a most credulous being and the more fantastic the claim of the fakir the more ready he seems to be to believe in him. We find a class of the clergy personally interested in financing medical "institutions," which simply could not exist did they depend

on the legitimate practitioner for the conduct of treatment given. The tagging of such an institution with a semi-religious name and the appealing to churches and Sunday schools to aid in raising funds for the erection of a building and the exploiting of the enterprise as a charity where unfortunates with various addictions may be treated, and that under strict religious supervision, is an old story. Our best hospitals and sanitariums are under religious supervision, and so are our worst; the one is a great benefit to the world, the other a curse. One of the prominent Rev. Drs. of our city has lately discovered an "unambitious genius" who has discovered a treatment for the cocaine habit. He says "the treatment is a boon to humanity, and hopes it may be generally adopted and hospitals instituted throughout the country." The Rev. Dr. is announced as "principal promoter," and funds are to be raised for the erection of a hospital here at once. The institution is to be given a suggestive name of the "Door of Hope" order and regeneration of unfortunates begun. No doubt the "principal promoter" will make a good thing out of it, his start leaves no impression of other purpose in the minds of those who know what honest and legitimate medicine mean.

We have a profound respect for the really religious, and would be the last to hold up to ridicule anything really worthy of the name, but the ministerial medical-testimonial writer and the ministerial promoter of irregular medical institutions hardly come in the category of things worthy of profound respect.

THE profession is reasonably conversant with the fact that many evils attend medical charity,

Medical Charity Evils.

and while it is an easy matter to point out such abuses, and especially so when they exist in another's clinic, it is quite another

thing to supply a remedy which will not work hardship on the deserving poor. Because a man is so poor that he has to accept free medical aid is no indication that such a fact should be branded on him; he may have a pride which is quite as genuine as that of those in better circumstances, and his misfortune should not be paraded. That a few who are able, and well able, to pay for medical service do come to almost every clinic is not to be avoided without material distress to a deserving class whose need entirely outweighs any other consideration. We have felt a high appreciation of the exposure of

medical evils which is appearing in the Chicago Clinic, and we appreciate the fact that St. Louis comes in for censure which is our due; but a fair familiarity with the clinics of the city leads us to the conclusion that the investigator must have been very unfortunate if he did not find that the clientele is made up of a vast number of the very poor, of shop girls and boys who are trying to keep body and soul together on two or three dollars a week, and on even less, with a scattering few who possibly may be able to pay a physician. Every large city has a tremendous population which is *poor*, such poverty is theirs as no one but the clinic physician and the charity worker dreams of, possibly they might better their circumstances in a smaller community, but they do not know how to move, or where to go, nor have they the means to go with did they know. The clinic which does not a legitimate charitable work soon dies. The clinic which can boast of 15,000 patients in a year is doing a tremendous charitable work without which the city would find its institutions overcrowded, and its death-rate greatly increased. These people simply have to depend on the clinic, and it is fortunate that it is so conducted as not to appear as charity in the ordinary acceptance of the term, else they would refuse it and suffer, as they are so fortunate as to have still lingering within them that spark of independence which is American, and which it is American to foster. The larger number of our clinical dispensary physicians honestly endeavor to weed out all but the worthy poor, the exception is rare in spite of reports to the contrary.

The remedy for such evils as exist in clinics we await with eagerness, but we believe they will continue so long as people who can pay and who should pay will accept free attention from physicians. The complaint of physicians against the clinic emphasizes the facts that we have an already overcrowded profession, that doctors, like the poor flock to the cities when they might better stay in the country, and that some doctors always have an explanation for the absence of patients from their offices other than personal inefficiency, which is in many cases the real reason behind their troubles.

THE date of the Atlantic City meeting of the A. M. A. is fast approaching, and it is time to have preparations for the trip well under way. We find that the St. Louis delegation this year is to include a considerable amount of new blood, and

there is a considerable degree of enthusiasm over the meeting and the attendant privileges. The coast region, with its many cities and many points of interest, offers many inducements and a consideration of side trips is an important one. Unless these be of short duration, the time limit of the tickets will allow of but one or two, and the different cities and the Jamestown Exposition are proving a difficult choice. It appears that a majority will avail themselves of the offer of the Big Four-C. & O. route, which makes both Washington and the Exposition available on one side trip; others will make a hurried trip to New York and go direct from that point to the exposition, while a few will omit the exposition feature entirely. The train will leave St. Louis Saturday noon, giving a daylight ride through the Virginia mountains and the Shenandoah Valley, arriving in Atlantic City early Monday morning. Should there be a sufficient number to insure a full train a special will be run and Atlantic City be reached Sunday evening. Sleeper reservation should be made at once, and may be made either through the local Big Four agent, or through the editor of the FORTNIGHTLY.

A cordial invitation has been extended by Mr. Fred Sterry, manager of the New Homestead Hotel, to spend Sunday at Hot Springs en route, and a complimentary luncheon will be spread for the doctors and their families. Those who desire to make this stop will reach Atlantic City Monday morning.

Hotel accommodation should also be secured well in advance, and we would suggest the Grand Atlantic, which is but a few steps from the Steel Pier, where the sections on Medicine, Surgery, Obstetrics and Hygiene meet, and but a short walk from Young's Pier where the Exhibits and Postoffice are located, and which will be social headquarters as usual. Reservations should be made without delay.

THE most notable event since our last issue which concerns the medical profession was the memorial celebration of the twenty-fifth anniversary of the death of Dr. John T. Hodgen, which took place

The Hodgen Memorial.

on the afternoon of Sunday, April 28th, under the auspices of the St. Louis Medical Society. Committee of nine having in charge the preparations for the occasion under the leadership of Drs. Outten, Homan and Stevens, arranged the following program: Invocation—Rev. Samuel J. Niccolls D.D. Dr. Hodgen as a National and International

Figure in Medicine. Joseph M. Mathews, M. D., of Louisville, former President American Medical Association.

His Educational Influence in the Mississippi Valley. Warren B. Outten, M.D., Chief Surgeon Missouri Pacific Railroad.

The Debt of Missouri to his Example and Memory. Charles H. Wallace, M.D., of St. Joseph, Mo., President Missouri State Medical Association.

His Worth as a Citizen. Charles Nagel, Esq., of the St. Louis Bar.

His Power and Influence as a Teacher over his Classes. Henry C. Fairbrother, M.D., of East St. Louis, Illinois.

His Student and Social Life. LeGrand Atwood, M.D., of Ferguson, Mo.

Benediction.

Without exception the speakers were present and the addresses were of such scholarly character as to be definitely impressive and inspiring, making the occasion one long to be remembered. The audience was in a large part composed of Dr. Hodgen's former pupils and friends, many of whom came to the city from a distance for the occasion. The following sketch of the life and character of Dr. Hodgen appeared on the program, and contains matter which should be familiar to every physician in the Mississippi Valley:

John Thompson Hodgen was born at Hodgenville, LaRue County, Ky., not far from the birth place of Abraham Lincoln, on the 19th of January, 1826. His father was Jacob Hodgen; his mother, Frances Park Brown.

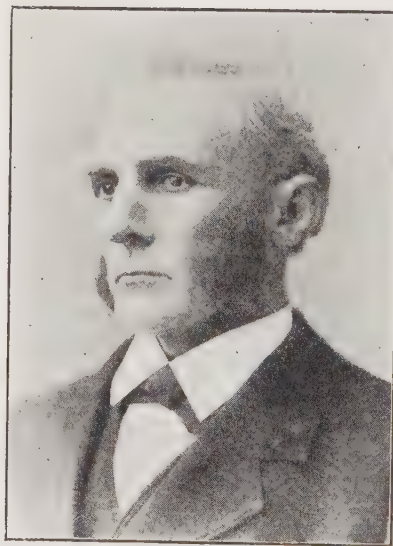
His early years were spent in the common schools of Pittsfield, Pike county, Ill., and his collegiate course at Bethany College, West Virginia. In his twentieth year he entered the medical department of the University of the State of Missouri.

He graduated in March, 1848; was assistant resident physician of the St. Louis City Hospital from April, 1848, to June, 1849, and was demonstrator of anatomy in his Alma Mater from 1849 to 1853. He was appointed to the chair of anatomy by Joseph Nash McDowell, which position he occupied from 1854 to 1858. From 1858 to 1864 he filled both chairs of anatomy and physiology.

In 1864, the Missouri College building having been seized by the Government, and Dr. McDowell, its head, having gone South, Dr. Hodgen transferred his allegiance to the St. Louis Medical College, where he filled respectively the chairs of physiology and of anatomy. In 1875 he assumed the chair of surgical anatomy, of fractures and dislocations, and was created dean of the faculty, which position he held at the time of his death. During the eighteen years from 1864

to 1882 he taught clinical surgery at the City Hospital.

During the Civil War he served in the capacity of surgeon-general of the Western Sanitary Commission, 1861; surgeon United States Volunteers, 1861 to 1864; and surgeon-general State of Missouri, 1862 to 1864. He served as consulting surgeon of the City Hospital from 1862 to 1882, and was president of the St. Louis Board of Health from 1867 to 1868, and a member of that body until 1871. In this position he was instrumental in organizing on an efficient basis the charity hospitals and dispensaries of the city. He was president of the St. Louis



DR. JOHN T. HODGEN.

Medical Society in 1872, was chairman of the surgical section of the American Medical Association in 1873, was president of the State Medical Association in 1876, and was president of the American Medical Association in 1880.

Quick and clear in apprehension, terse and forcible in expression, he was a powerful debater, whom no sophistry confused, and one who never lost sight of controlling principles, nor confounded ideas with facts. In the International Medical Congress in 1876, at Philadelphia, he won substantial honors, and made a record that stamped him as a great man in the midst of the greatest the civilized world could produce.

He possessed decided mechanical genius, the inventions most worthy of note being wire splint for fracture of the thigh; sus-

pension cord and pulleys, permitting flexion, extension and rotation in fracture of the leg; forceps dilator for removal of foreign bodies from the air passages without tracheotomy; cradle-splint for treatment of compound fracture of the thigh; wire suspension splint for injury of the arm; double action syringe and stomach pump; hair-pin dilator for separating lips of the opening in the trachea, and as a guide to the trachea tube.

His chief contributions to medical literature were Wiring the Clavicle and Acromion for Dislocation of the Scapular End of the Clavicle; Modification of Operation for Lacerated Perineum; Dislocation of Both Hips; Two Deaths from Chloroform; Use of Atropia in Collapse of Cholera; Three Cases of Extra-Uterine Fecundation; Skin Grafting; Nerve Section for Neuralgia; Report on Antiseptic Surgery; Shock, and Effects of Compressed Air, as observed in the building of the St. Louis and Illinois Bridge.

He died in his fifty-seventh year of acute peritonitis, caused by ulceration of the gall-bladder, after a short and painful illness.

He loved his profession, was quick to cheer and help the meritorious and struggling young student and practitioner, and of a free and open nature. He was easy and familiar with the younger members of the profession, rejoiced in their emoluments, success, and honors, and gave them full meed of praise when merited, and never sought to monopolize the honors of his calling. Broad and liberal in his views, and original and independent in thought and action, he was a standard-bearer of progress in the medical profession. The poor received his ministrations without price, and he made no distinction in his treatment between the rich and the poor.

A man in the fullest and highest sense of the word, ever true to his convictions of right, loyal to his friends, tender in sickness and sorrow, wise and cultured from extensive and thoughtful reading, but much more so from direct and constant insight into the human frame in health and disease, the memory of John T. Hodgen will long be cherished as an enduring honor to St. Louis, the city of his adoption, and to the profession which he honored and ornamented, and to which he was a benefactor.

OSLER'S MODERN MEDICINE.—The announced volume on practice from the pen of Dr. Osler is before us, and while it will be suitably reviewed later we feel that our readers are interested in the fact that so notable a work is now obtainable. It has been

planned in the belief that the great advances of the past decade should find expression in connection with previously established knowledge, so that every physician should be able to place himself upon the plane of the highest development, not only in theory, but also and more particularly in practice. This far-reaching conception has been carried out irrespective of cost with confidence in the appreciation of the profession in all English-speaking nations, hence it has been possible to place such a work within reach of all. Dr. Osler and his publishers Lea Brothers & Co., Philadelphia, have done the American profession a distinct and definite favor, and one which must meet with wide appreciation, for the book is easily the best work on practice now available.

DEATH OF THEO. D. BUHL, PRESIDENT OF PARKE, DAVIS & Co.—The medical profession generally have felt profound sorrow over the death of the president of Parke, Davis & Company, Mr. Theo. D. Buhl. Mr. Buhl had been connected with this house better than ten years, and his keen insight, good judgment and thorough understanding of the medical profession and its needs have been strong factors in the prominent place Parke, Davis & Co. holds. The following memorial resolutions were adopted by the Board of Directors of the house on behalf of the stockholders:

Ten and a half years ago Theodore D. Buhl cast in his lot with this house. Throughout that period he has given us the benefit of his large experience, his sound judgment, his great power in the commercial world, his granite credit reared on an unwavering honesty. As president of the house he was the perfect type of integrity and fidelity to all the stockholders. His high sense of duty as a trustee pledged to administer the property and guard the interests of others, was ever uppermost in his thoughts. The peculiar responsibilities and hazards of our work—our obligations as purveyors to the medical profession and to suffering humanity, were to him always a solemn appeal. The ultimate triumph of character in business was with him a conviction as deep and strong as instinct. The remote future and the distant prize concerned him more than the present gain.

The strength which he gave this house and all the many enterprises in which he shared, signally exhibits what the world should realize especially at this hour—that rich men of unflinching honesty and sound judgment are of inestimable value to their communities. They are the employers of labor, the authors of new industries, the creators of new values,

the pioneers who open up vast avenues of opportunity for their followers. As they succeed or fall, the comfort, the very bread, of thousands is assured or endangered. We hear much these days of unscrupulous, predeceous wealth, but what of the type of Theodore Buhl—what of the men who consider the trust of their fellowmen the best of their possessions, who have a horror of stock-jobbing methods, who never seek an unfair advantage, who never lend their names to a dubious enterprise?

As a director Mr. Buhl was the soul of courtesy, kindness and deference. As an employer he was considerate, thoughtful, mindful of the comfort, interests and claims of his employes. To their grievances he gave always a patient and attentive ear. He encouraged the manly expression of honest opinion, and when it differed from his own his effort was to convince and persuade, not to invoke his authority or impose his will.

On behalf of the stockholders, employes and executives of Parke, Davis & Company we record this testimony to the lasting service rendered us by our lamented President. To the members of the bereaved family we offer our warm and heartfelt sympathy. May strength be theirs to bear their sorrow. May they find much comfort in the memory of a life rich in well-doing and in good repute.

MIXTURE TO LUBRICATE URETHRAL SOUNDS.—M. Casper uses the following preparation to lubricate urethral sounds. It is very unctuous, is easily washed off and its antiseptic action lasts for a long time:

R Mercury oxycyanid.....	gr. 4
Gum tragacanth.....	gr. 45
C. P. glycerine.....	3 5
Aq. dest.....	3 6½

—Amer. Medicine.

SOAP LINIMENT.—

R Castile soap, in powder.....	gr. 70
Camphor, in small pieces...	gr. 45
Ol. rosemary.....	c. c. 10
Alcohol.....	c. c. 750
Aq. q. s. ad.....	c. c. 1000

Mix the ingredients (except the water) together in a bottle, shake until the camphor is dissolved, then add enough water to make up the required volume, and shake; filter.—Med. Sum.

ECZEMA OINTMENT.—

R Beta naphthol.....	1 drachm
Sulphur.....	2 drachms
Balsam peru.....	1 drachm
Petrolatum.....	1 drachm

M. ft. unguentum.—N. Y. Med. Jour.

SOCIETY PROCEEDINGS

MEDICAL SOCIETY OF THE MISSOURI VALLEY.

Semi-annual meeting at Omaha, March 21, 22.

(Continued from page 195.)

TREATMENT OF MORPHIN HABIT.

DR. W. F. WAUGH, Chicago, stated that, inasmuch as toxin retention is the disease, elimination is the remedy. Withdrawal symptoms, he said, are an evidence of auto-toxemia. By eliminating the toxins as fast as they are poured into the system there will be no withdrawal symptoms. He has treated a considerable number in this manner with great success.

NON-OPERATIVE TREATMENT OF GASTRIC DISEASES.

DR. F. B. TURCK, Chicago, said that cases which manifest disturbance of function, but where no stenosis is found, do not demand surgical treatment, but rather physiologic methods of treatment; that is, dietetic, physical and mechanical. Operative treatment is indicated when there is obstruction of the stomach outlet, as in benign superficial stenosis or early malignant growth, when the diagnosis is uncertain and characterized by progressive loss of weight and when all symptomatic treatment fails.

PELVIC ABSCESS.

DR. W. T. ELAM, St. Joseph, Mo., advocated hysterectomy by the two-stage method in case of multiple abscesses of the uterus, vaginal drainage in walled-off abscesses, salpingectomy or oophorectomy, when demanded, as secondary measures. In cases of chronic pyosalpinx the abdominal route is preferred.

HERNIA.

DR. D. C. HILTON, Lincoln, Neb., classifies hernia as follows: (1) Hernioida protrusa and (2) hernia vera. Among the first are cases of protrusion invested by the mucocutaneous membranes of the body through an orifice of the mucous or cutaneous surface. The second class, hernia vera, comprises the congenital and acquired hernia. This classification is based on the conception that the body is a tube, the continuous covering of which is epithelium, which spreads over the general inner and outer surfaces of the tube, and also into all diverticula and recesses.

EXPERIENCE WITH MORPHIN-HYOSCIN COMPOUND.

DR. F. E. WALKER, Hot Springs, S. D., reported 75 cases in which he made use of

this compound with most excellent results. No untoward symptoms were observed and no evil effects were noted; he recommends smaller dosage, and the addition of chloroform in some cases.

DANGERS FROM TUBERCULOUS MILCH COWS.

DR. R. S. TOWNE, Omaha, stated that evidence is accumulating supporting the theory that infection of the lung occurs not by inhalation, but by the ingestion of bacilli, and that there exists an intercommunicability of all types of tuberculosis, the bovine being the most active. He emphasized the greater susceptibility to tuberculosis of the child, and pointed out that milk must be reckoned with as a probable source of infection in tuberculosis. He said that any system of prophylaxis which ignores the tuberculous milch cow must be considered incomplete.

TREATMENT OF EXOPHTHALMIC GOITER WITH ELECTRICITY.

DR. R. D. MASON, Omaha, reported one case in which the main feature of treatment consisted of the introduction into the thyroid of iodine by cataphoresis. The patient, aged 45, had manifested symptoms for two years. Treatment was instituted six months after the onset of the disease and was given twice a week for six weeks. Strychnin was the only agent given internally. Improvement was marked and steady from the beginning of the treatment. The circumference of the neck finally was two inches less than when the patient was first seen, although the pulse rate was still about 100, and the pulse was quite irregular. The tremor was much improved, there was no pain, the eyes were normal, and insomnia, from which the patient had suffered severely, was relieved.

OTHER PAPERS READ.

The following papers were also read:

"Gall Bladder Disease," by Dr. A. L. Wright, Carroll, Iowa; "Specialism," by Dr. P. I. Leonard, St. Joseph, Mo.; "Some Views on Appendicitis," by Dr. C. O. Thienhaus, Milwaukee; "Pulsating Exophthalmos Treated by Excision of the Superior Ophthalmic Vein," by Dr. H. Gifford, Omaha; "Renal Calculi," by Dr. B. A. McDermott, Omaha; "Vesicovaginal Fistula," by Dr. F. A. Long, Madison, Neb., and "Anterior Suspension of the Uterus," by Dr. F. B. Dorsey, Keokuk, Iowa.

The annual meeting will be held in Council Bluffs, Iowa, Sept. 5, 1907.

PHYTOLACCA is of value in glandular and lymphatic involvements.



THE MEDICAL FORTNIGHTLY

A Cosmopolitan Biweekly for the General Practitioner

The Medical Fortnightly is devoted to the progress of the Practice and Science of Medicine and Surgery. Its aim is to present topics of interest and importance to physicians, and to this end, in addition to a well-selected corps of Department Editors, it has secured correspondents in the leading medical centers of Europe and America. Contributions of a scientific nature, and original in character, solicited. News of Societies, and of interesting medical topics, cordially invited.

Advertising forms close on the first and fifteenth of each month. Time should be allowed to submit proof for correction. Advertising rates on application.

Remittances and business communications should be addressed to the Fortnightly Press Co.

Subscription, \$2.00 a year, in advance, including postage to any part of the United States, Mexico and Canada. Postage to foreign countries in the Universal Postal Union, including Newfoundland, \$1.00 a year additional. Entered at the St. Joseph post-office as second-class matter.

The Medical Fortnightly will not be discontinued at expiration of subscription, as many of our readers prefer not to have their files broken on account of failure to remit. Unless we receive a distinct request to discontinue, and payment for all arrears, this magazine will not be discontinued.

Subscriptions may begin at any time; volumes end with June and December.

Contributors should understand that corrected typewritten copy is essential to clean proof and prompt publication, and is much more satisfactory than manuscript. Original articles should be as condensed as justice to the subject will allow.

Editorial offices in St. Louis and St. Joseph, where specimen copies may be obtained, and subscriptions will be received.

Contributions and books for review should be addressed to the Managing Editor, 319 and 320 Century Building, St. Louis, Mo.

SELECTED ITEMS

WHAT THE AILMENT WAS.—When Senator Hoar learned that a friend who they thought had appendicitis was in reality suffering from acute indigestion, he smiled genially. "Really," said he, "that's good news. I rejoice for my friend that the trouble lies in the table of contents rather than in the appendix."—May Lippincott's.

POSTPONED.—When the lady from next door called to complain of Tommy for the persecution of her pet cat, she found the youthful offender sitting on the front steps.

"I want to see your father!" she exclaimed.

"You can't see pa now," the boy replied.

"I shall see him instantly," the lady insisted, advancing.

"All right," the little fellow agreed, opening the front door and slipping out of arm's length. "Walk right up-stairs. You'll find pa in the bath-room takin' a bath."—May Lippincott's.

THE ALIENIST AND NEUROLOGIST May number will give you an advanced and correct conception of the Nervous System in its Relation to Disease, general and special, its influence and how it is influenced in disease and cure of disease. Contains: Erotism (Normal and Morbid) and the Unwritten Law—Is Genius a Sport, a Neurosis or a Child Potentiality Developed?—Is Sexual Perversion Insanity? — A Psychological Medico-Legal Study—The Tramp as a Social Morbidity—The Entoning of the Neurons in the Practice of Medicine and Surgery—A Case of Canine Hermaphroditism—Man's Moral Evolution: The Creeping Serpent in our Garden of Eden—One of those Erotopathic Women—Chorea Considered as a Neurohumoral Disorder—Hysterical Stigmata in Court—The Unstable Psychic Neuron—The Tetanic and Septic Dangers of Gelatin—Epileptics Refused Salt—Christian Science's Rival—An Interesting Question in the Testimony of Mrs. Thaw—A Rare Note of Thankful Obligation—Brain Storms—An Extremely Young Girl Suicide—The Spread of the Insane Brain Storm Idea—Alcohol—Phases of the Thaw Trial—Legal Juggling of the Experts in the Thaw Trial, etc. Also the usual number of selections on psychiatry, neuriatry, psychology, neurology.

THE COST OF RAPID TRAVEL.—The accidents recurring on our railroads, with all their fearful loss of human life, must cease to appear to the thoughtful as a mere misfortune; they have become in a truth a national disgrace. If, as a people, we were marked by slow intelligence, or were prevented from showing our resourcefulness by pinching poverty, some just excuse might possibly be found for these mishaps. But Americans do not instinctively regard themselves as inferior to others in the wit which deals with engineering and mechanism and in that rarer knack of organizing and directing to a single purpose the ingenuity of many men. Nor, when we consider the unwonted wealth coming to our corporations, would we plead in their behalf the hindrance due to narrow penury, which cramps their natural efforts to protect to the full the lives entrusted to their care. Reluctantly one is almost compelled to believe that the defect lies somewhere on the moral side. Those who direct our passenger service, as well as the public generally, have been far too lenient regarding great catastrophes; we have too readily accepted them as part of the inevitable cost of rapid travel.—George M. Stratton in the May Century.

THE MAY ST. NICHOLAS.—There are the beginnings of two enticing new serials in the

May St. Nicholas—short serials by popular writers are a delightful feature of the magazine this year. The first is a story of old London town, "A Little Field of Glory," by Mary Catherine Lee, author of "A Quaker Girl of Nantucket," "Lois Mallet's Dangerous Gift," etc., with pictures by Reginald Birch. Ralph Henry Barbour's new story begins in this number, too—"Tom, Dick and Harriet," the scenes and several of the characters being those of "The Crimson Sweater." There are also new adventures of Fritz and Pinkey Perkins, and stories by Mildred Stapley, "The K. and A. Company," "Dorothea's May Basket," by Claire H. Gurney, and, for very little folk, "The Bearkins at the Farm." Of more serious articles, there is a sympathetic study of Henry D. Thoreau, "The Man Who Was Always a Boy," by Gilbert P. Coleman; and Charles Barnard gives an interesting account of the workings of the Telharmonium, that wonderful invention. And there are hours of profitable entertainment for big and little in Nature and Science, the St. Nicholas League, and the "Hints and Helps for Mother," this time all about the fun to be had out of newspapers.

PROSTATITIS.—The Indian Medical Record gives the following prescription for prostatitis:

R Tinct. opii camp. 1½ ounces
Liquor potassii. 2 drachms
Tinct. lupulini. 4 drachms
Tinct. hyoscyami. 2 drachms
Syrupi zingiberis. 3 ounces

M. Sig.: Teaspoonful in half glass of water after meals and at bedtime.

TOOTHACHE.—For pain due to pericementitis, J. P. Buckley uses:

R Tinct. aconiti. 3j
Chloroformi. 3iv
Menthol. gr. x

M. Sig.: Paint over gums.—Dental Review.

FOR SCABIES.—The following combination will speedily cure most cases of scabies:

R Beta-naphtholis. gr. xx
Sulphuris loti. 3j
Balsami peruviani. f3j
Unguenti zinci oxidi. 3j

M. ft. unguentum. Sig.: Apply locally to the parts affected twice daily.—Medical Bulletin.

DR. R. B. H. GRADWOHL announces the removal of his office and laboratory to suite 223-224 Victoria building, 8th and Locust streets. Office hours: 9 to 12 a.m., 2 to 5 p.m.

MEDICAL MEMORANDA.

For Sale.—First class vibrator (electric) and static machine, little used. A great bargain. Address, "Retired" care Medical Fortnightly, St. Louis, Mo.

I recommend resinol soap for general family use. I find it very good for the care of the face and the preservation of the hair.—W. A. Wenger, M. D., St. Paul, Minn.

Convalescence from all acute infectious diseases, such as typhoid fever, la grippe, pneumonia, diphtheria, etc., is hastened by the use of Gray's glycerine tonic comp. It is an unequalled restorative, reinforcing nature's recuperative powers. Its palatability makes it always acceptable to the stomach, upon which organ it has a specific, tonic, alterative, stimulant and restorative influence. It engenders appetite and eradicates tonicity of the digestive organs.

Sal Hepatica in Inflammatory Conditions of the Bowels.—It is claimed that sal hepatica can be employed as a laxative and eliminant of irritating toxins with safety and satisfaction in inflammatory conditions of the bowels and is worthy of a prominent place in the diarrheas of infancy and childhood, and in "summer complaints" which arise from fermentative and putrefactive causes. It is less obnoxious to the organism than sodium phosphate alone, or other saline laxatives, and it is more readily eliminated by the excretories and emunctories without inculcating an objectionable tax thereon. Sal Hepatica is an ideal laxative for all ages and conditions. It is not in the least depressing, but on the contrary, is a physiological tonic; its use does not establish toleration leading to increased dosage; and its withdrawal, unlike many other agents, does not leave the bowels more constipated than at the beginning. It is a safe laxative during pregnancy and lactation or in the presence of anemic chlorosis.

An Efficient Formula for Use in Rhinitis.—(By Dailey Appleberry, M. D., St. Louis, Mo.)—During the changeable spring weather it is no unusual matter for the physician to be called upon by his patients to treat their nasal troubles, among which the most common is, beyond all doubt, that catarrhal inflammation of the schneiderian membrane which is currently called rhinitis. It is that form which is not only annoying but very often painful. Among the symptoms which may manifest themselves are pruritus as well as an accompanying anemia, both of which are exceedingly unpleasant to those so effected. There are many practitioners who begin treating such cases by at once cauterizing the mucosa with stick nitrate of silver, with chromic acid, with the acid nitrate of mercury or even with the galvano-cautery. These are methods which are but seldom indicated and should but rarely be employed, as the result of their use culminate in scars and a disagreeable condition of the nasal cavity with the constant formation of crusts. Not long since I had occasion to see and examine some patients affected with such catarrhal rhinitis and the appearance presented was that of an angry-looking mucous membrane whose secretion was pronounced and inclined to become purulent. In all of these the patients were ordered to take appropriate tonic remedies and for local applications the following was ordered to be applied three or four times daily:

℞ Hydrar. bichlor.....	gr. ¼
Katharmon	ʒvi

M. Sig.: Use four times daily in nose.

This acted like a charm, and in a comparatively short time my patients reported themselves well. It would not be a bad idea to combine white liquid hydrastis with the above; but, above all, see that there is a liberal amount of katharmon, for that is the ingredient that does the work. Those colleagues who will employ the above formula will find it among the valuable ones they possess.

Ergoapiol (Smith): Its Therapeutical Indications: with Clinical Notes.—(By C. W. Canan, B.S., M.D., Ph.D.) We desire to call the attention of the medical profession to a new pharmaceutical product possessing valuable therapeutic virtues in many diseases peculiar to women. This remedy is known as "ergoapiol (Smith), and since its introduction to the profession it has rapidly gained favor with our best physicians. It is strictly ethical, manufactured from the purest drugs and advertised only to physicians. It is the result of an original combination of the following remedies: apiol, ergotin, oil of savin, and aloin, all of which are freed from toxic and deleterious substances. These agents are blended in such proportions as to overcome the powerful irritating qualities of each and raise the tonic properties of all. A glance at the therapeutical indications of these remedies singly will convince the most sceptical of the virtues of "ergoapiol"—the result of their combination. Since the days of Jaret, Homolle and Baillot, apiol has gradually grown in favor as a therapeutical agent, but until recently it had one decided drawback, that of containing deleterious and toxic impurities in combination. Recently, through the skill of the never-tiring pharmacist, these have been eliminated, and it can now be prescribed without fear of producing disagreeable symptoms, but with an assurance that its further therapeutic virtue will be realized. Even in its impure state apiol gained considerable reputation in the treatment of nephritis, dropsical effusions, amenorrhea and dysmenorrhea. Its emmenagogue properties have been greatly enhanced by the removal of all impurities. In small doses it now became a mild aromatic stomach tonic; it is also highly recommended in membranous dysmenorrhea. The therapeutical value of ergotin is too well known to call forth comment here. Combined as it

is in "ergoapiol," it becomes an excellent adjunct to apiol, and adds very materially to the efficiency of the finished product. All students of medicine are aware that oil of savin is a powerful and valuable stimulant to the uterine system, and is one of the most potent emmenagogues known. It is also a powerful gastro-intestinal irritant, and therefore is seldom prescribed alone. But when combined with certain correctives, as it is in "ergoapiol," it becomes a valuable addition to the drugs already named—apiol and ergotin. Since the discovery of the methods of producing aloin from the different brands of aloes this drug has become very popular, and has taken the place of the crude drug to a considerable degree. Aloin enters into almost every emmenagogue pill and mixture. Its value as a therapeutical agent is so well known that it is not necessary for us to speak of it in detail; yet we desire to say that its addition to the drugs in question aids very materially in making "ergoapiol," so valuable a combination. Being a mild stomach tonic, it aids in overcoming the irritable qualities of the savin; also acting as a hepatic stimulant, freeing the portal circulation and relieving that condition so often present in diseases of women—pelvic engorgement. These qualities make it an ideal adjunct to the emmenagogues mentioned. Our attention was called to "ergoapiol" (Smith) through a reprint from a St. Louis journal. This reprint gave the names of remedies entering into the combination. We at once concluded that this product would be a useful one, and securing a supply we began prescribing it whenever indicated. The results were even greater than we had anticipated. From the beginning we have kept clinical notes of each case, some of which will be recorded in this article. "Ergoapiol" is a mild, aromatic stomach tonic, anodyne, antispasmodic and hepatic stimulant. It is also a laxative, an ideal emmenagogue in the full sense of the term, and exerts a decided tonic influence upon atonic conditions of the pelvic viscera. It is indicated to a greater or less extent in all forms of dysmenorrhea, viz., atonic, congestive, obstructive and membranous. In true obstructive dysmenorrhea due to actual stenosis of the uterine canal, to a sharp flexure of the organ, or to the valve-like action of a clot or a polyp it is seldom indicated because this form of organic dysmenorrhea requires either surgical operation or mechanical means to effect a cure. However, good results may be expected from its use after such operations have failed to complete a cure or to relieve the suffering. It is even useful in the form where clots cause the trouble by their mechanical obstruction, and we have seen its administration cause the passage of a polyp in one patient. Good results may be expected from its use in that form of dysmenorrhea known as membranous, due to an exfoliation of the endometrium in the form of a membrane. In amenorrhea it is far superior in value to any remedy we have yet tried, if the cases are properly selected. Amenorrhea due to taking cold at the menstrual period, or caused by shock, can be relieved with the remedy in question. This remedy is occasionally beneficial in certain forms of metrorrhagia, after operations to remove fungoid or polypoid growths, or after cur-retting the uterus. It is a remedy of great value in menorrhagia, especially in that form due to fecal impaction, with torpidity of the liver in persons nearing the menopause. Where this trouble occurs in a plethoric and indolent subject the following plan of treatment will generally be all that is necessary: Begin three or four days before menstruation is due and give one brisk mercurial purge, then follow with "ergoapiol," one capsule three times per day. If this plan is carried out for several months at each menstrual period, a cure will be the result. "Ergoapiol" is especially indicated when disturbances of menstruation occur in feeble and anemic women. It should be alternated with some form of iron in such cases. There is a condition in which the patient's menses are regular as far as time is concerned, but the flow is very scant, exceedingly thick, tarry in color, with an offensive odor. The patient suffers pain and weight in the pelvis and back; is despondent, loses flesh and strength, and may or may not suffer from various reflex disturbances. In this state of affairs "ergoapiol" will be found a sheet anchor. Before recording the clinical notes gathered while prescribing the drug under consideration, we wish to call attention to one or two important things before leaving the subject. The first is that form of amenorrhea that is brought about by constitutional disease, such as tuberculosis. In these conditions it is a common occurrence to have women insist on their physicians giving them something to bring on menstruation, thinking that its absence is the cause of their condition, when the fact is, the stopping of menses is only a wise provision of nature to prevent faster decline of vital forces. The course to be pursued is to treat the constitutional disease, and when a cure of the latter has been accomplished, this form of amenorrhea will generally take care of itself. However, when the patient's general health has been restored and the function fails to return, then "ergoapiol" can be prescribed with good results. Our second subject is that of prescribing emmenagogues indiscriminately without regard to the cause of amenorrhea. Women who know or suspect themselves to be pregnant, frequently consult a physician in the hope that, in the attempt to bring on menstruation, he will really succeed in causing abortion. Whoever, under such circumstances, prescribes "ergoapiol" with the understood purpose of inducing the menstrual flow, is liable to have criminal charges brought against him in case abortion actually does take place, even as the result of something the woman has taken or done herself. Before prescribing "ergoapiol" in amenorrhea the physician should satisfy himself that pregnancy does not exist, and in case of doubt he should decline the management of the case, unless he can protect himself by securing some trustworthy consultant who will share the responsibility of the case.